DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10138 (01/04)

STATE OF WISCONSIN
WI. Stats s. 49.47

MEDICAID / BADGERCARE SUPPLEMENT TO FOOD STAMP APPLICATION

This form is used as a supplement to the Food Stamp Only Application. Complete this form only if you are applying for food stamps and Medicaid.

SECTION I – APPLICANT INFORMATION

Applicant Name (First, MI, Last)	Applicant Address (Street, City, State, Zip Code)

SECTION II – PREGNANCY (Add a second sheet of paper if more room is needed.)

Is any member of your household pregnant? ☐ Yes ☐ No	Name of pregnant woman	Due date	If multiple births are expected, list number of babies.

SECTION III – CURRENT INSURANCE COVERAGE

Does anyone in your household have medical / health insurance coverage now, or in the previous three months?
☐ Yes ☐ No

SECTION IV – CURRENT INSURANCE INFORMATION

List the name and address of the insurance company

List policyholder's name (First, MI, Last)

Policy Number	Effective Date	Date Ended

List the names of all household members (including applicant) that are covered by this insurance.

Name (First, MI, Last)	

SECTION V – SIGNATURE

I understand that as a condition of eligibility for Medicaid I must report to the county/tribal social or human services agency any other person(s) that may be liable to pay for medical care for my family and me. I must also cooperate by giving information to assist the county/tribal social or human services agency in pursuing payment from any other person(s). I understand that any benefits for the cost of medical care which are available under a policy will be assigned to the State by law (s. 49.45 (19), WI Statutes.) during any period of Medicaid eligibility. I understand that within 10 days I must report any changes in all of the above information. The information given above is true and complete to the best of my knowledge.

SIGNATURE – Applicant or Authorized Representative	Date Signed

RESET

RIGHTS AND RESPONSIBILITIES

Your signature on the application means that you understand and acknowledge that the county/tribal social or human services agency, W-2 agency and the state Department of Health and Family Services is authorized to request any information that is appropriate and necessary for the proper administration of Wisconsin Medicaid as authorized under Wisconsin law.

Any person, including any financial institution, credit reporting agency, employer, or educational institution, is authorized to release this information, according to Wisconsin Statute s. 49.22(2m)(a): "The Department may request from any person in this state information it determines appropriate and necessary for the administration of this section, ss.49.141 to 49.161, 49.19, 49.46, 49.468 and 49.47 and programs carrying out the purposes of 7 USC 2011 to 2029. Unless access to the information is prohibited or restricted by law, or unless the person has good cause, as determined by the Department in accordance with federal law and regulations, for refusing to cooperate, the person shall make a good faith effort to provide this information within 7 days after receiving a request under this paragraph. Except as provided in subs. (2p) and (2r) and subject to sub.(12), the Department or the county child support agency under s.59.53(5) may disclose information obtained under this paragraph only in the administration of this section, ss.49.141 to 49.161, 49.19, 49.46 and 49.47 and programs carrying out the purposes of 7 USC 2011 to 2029. Employees of the department or a county child support agency under s.59.53(5) are subject to s.49.83."

You have the right to appeal any action taken concerning your Medicaid, BadgerCare, or Family Planning Waiver application or on going benefits that you do not agree with by requesting a Fair Hearing. You may request a Fair Hearing by calling or writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875
Telephone: (608) 266-7709

You can download the "*Request For a Fair Hearing*" form from the Division of Hearing and Appeals Web site at http://dha.state.wi.us/home/.

You may also contact your local county/tribal social or human services agency and ask for a Fair Hearing verbally or in writing.

The Department of Health and Family Services (DHFS) is an equal opportunity employer and service provider. For civil rights questions, call (608) 266-3465 (voice) or (608) 266-2555 (TTY).

To file a complaint of discrimination by contacting either the:

- Wisconsin Department of Health and Family Services (DHFS)
  Affirmative Action and Civil Rights Compliance Office
  1 W. Wilson, Room 555
  Madison, WI 53707-7850
  Telephone: (608) 266-9372 (Voice); (608) 266-5555 (TTY)
  Fax: (608) 267-2147

- U.S. Department of Health and Human Services
  Office for Civil Rights – Region V
  233 N. Michigan Avenue
  Suite 240
  Chicago, IL 60601
  Telephone: (312) 886-5077 (voice) or (312) 353-5693 (TTY)